Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11970257	A. BUILDING: _____ B. WING _____	12/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBORCHASE OF BOYNTON BEACH	11810 S MILITARY TRL BOYNTON BEACH, FL 33436

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A 000	Initial Comments AMENDED An uannounced Complaint survey (#2025009269, #2025011965, #2025009819, #2025009967, #2025008200 & #2025016566) was conducted on - at Harborchase of Boynton Beach. Deficiencies related to Complaint #2025011965 were identified at the time of the survey.	A 000		
A 032	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of	A 032		

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A 032	Continued From page 1 all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to reassess 1 out of 3 sampled residents (Resident #1) for continued residency after the resident had experienced a	A 032		

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A 032	Continued From page 2	A 032		

significant change that resulted in increased tendencies (elopement risk). Additionally, the facility failed to reassess Resident #1 to ensure the capability of the facility to provide appropriate care and services, including supervision, to an elopement risk resident.

The findings included:

A review of Resident #1's file revealed he was admitted to the facility on and resided in the secured (locked) memory care unit. Further review of Resident #1's file revealed his initial Resident Health Assessment (AHCA form 1823) dated that documented diagnoses of Right Branch Nephrolithiasis, . Additionally, his status was documented as , and he was independent for all activities of daily living (ADLs). Furthermore, it was reported that his needs could be met in an assisted living facility and he was not an elopement risk. Further review of the file revealed there was no documentation of progress notes in the resident's chart.

During an interview conducted with the Director of Nursing on at 9:45AM, request was made for any progress notes or incidents reports related to Resident #1. A review of the documentation provided by the Director of Nursing revealed a service plan (unsigned by Administrator or Director of Nursing) dated . Resident #1's service plan documented him as exit seeking and he required regular prompting due to and disorientation. Additionally, he was prone to agitation.

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A 032	Continued From page 3 Further review of the documentation provided by the Director of Nursing revealed two facility internal documents that documented elopements dated and . The reports stated the following: a) On Resident #1 eloped from the facility's secured memory care unit at approximately 6:15PM and was observing walking on the sidewalk away from the facility, heading south on Military Trail (major thoroughfare, west of the facility entrance by approximately 100 -150). The resident made it approximately half a mile (2640) before being stopped by a Private Duty Aid who worked for another resident at the facility. The aid redirected the resident into her vehicle and returned the resident to the secured memory care unit for assessment. The documented corrective action was to implement hourly check, place an alarm censor on egress doors, and place an identification on Resident #1. b) On Resident #1 eloped from the facility's secured memory care unit at approximately 7:20AM after experiencing an episode of agitation and could not be located. At 8:08AM the facility contacted 911 to report Resident #1 missing after conducting an in-house search. Resident #1 was later located by the police approximately 2 miles away (10,560) from the facility in a residential neighborhood. The documented corrective action included the implementation of a fence for the outer perimeter of the memory care, the reinforcement of the memory care doors with a mag-lock, supplying Resident #1 with an internal 1:1 companion for 5 days a week from 7a-7p while his private duty aid worked 7p-7am daily, and the use of an AirTag for locating the resident.	A 032		

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A 032	Continued From page 4 Further record review revealed Resident #1 was not reassessed for continued residency and to ensure appropriate supervision after elopement incident #1 (on). An updated Health Assessment form was identified for Resident #1. A review of Resident #1's updated Resident Health Assessment (AHCA form 1823) dated (completed 18 days after the second incident) revealed Resident #1 had diagnoses of , , and and Communication . Additionally, his status was documented as Alert and Oriented x1 and he was documented as an elopement risk. Resident #1 was also documented as requiring supervision and assistance with ADLs. During a confidential interview conducted on at 9:05AM, the first and second elopements dated and were confirmed. Additionally, a third elopment occurred on . During a tour of memory care on at 9:58 AM, roughly a dozen memory care residents were observed participating in an activity with 2 care staff, the Memory Care Director and 2 private duty aides present. When asked where Resident #1 was, the Memory Care Director stated he was in his room. At 10:05AM, Resident #1 was observed in his room (approximately 50 from the activity area) unsupervised. Resident #1 was conversational; however, he could not remember eloping from the facility the day before. He then informed the Agency that he liked to go outside and was outside often for work. At this time, the Memory Care Director informed the Agency that Resident#1's elopement episodes occurred whenever he thought he had work.	A 032		

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A 032	Continued From page 5 During an interview conducted with the Director of Nursing on at 12:22 PM, when asked about the facility's intervention process to prevent the elopement reccurrence for Resident #1, she stated that the resident only had a 1:1 staff sitter for a month and half. She further stated that the facility could not afford a 1:1 sitter for the resident and the facility was in the process of recommending a 24-hr private duty aid for Resident #1. At this time, she was asked to confirm if a third elopement occurred and she said yes, it occurred on . However, she did not provide any documentation of reassessment of the resident or any assessment of the systems the facility put in place to prevent recurrence. During a tour of the memory care unit with the local fire inspector and the Memory Care Director on at 10:11AM, the local fire inspector identified that the facility had no live video surveillance for the door that Resident #1 eloped from (dining room exit door in northwest corner of the building, 20 from Resident #1's room). Therefore, the facility was unable to monitor that area. Additionally, he identified concerns with the security of the facility's gate (northwest corner of the dining room surrounding the Memory Care perimeter with access to Military Trail) that required further investigation. At this time, the Memory Care Director stated that despite having door alarms, Resident#1 was able to elope due to the close proximity between his room and the exit door, therefore by the time the staff arrived at the door, Resident #1 was already outside. The fire inspector notified the Memory Care Director that the staff needed to be posted by this exit to ensure Resident #1 does not elope and the facility needs to reinforce their security for the	A 032		

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A 032	Continued From page 6 memory care unit. The Administrator was also unable to provide any documentation of further internal assessment of the 3 elopement incidents to determine if any other residents were at risks of exiting through the same area. The facility was also unable to provide any documentation indicating continued or updated elopement training after multiple reoccurences. During an interview conducted with the Administrator and the Director of Nursing on at 12:56PM, they were notified that the facility failed to reassess Resident #1 to ensure the facility could meet the resident's care needs, in addition to failing to assess the efficacy of the interventions that were implemented. Furthermore, Resident #1's exit-seeking behavior required continuous supervision and oversight from the facility that was not provided, due to a failure to implement an accurate and reflective service plan. Class III	A 032		